Minutes of the Special Meeting of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Thursday, July 18, 2019 at the hour of 9:00 A.M. at 1950 West Polk Street, in Conference Room 5301, Chicago, Illinois.

I. Attendance/Call to Order

Chair Hammock called the meeting to order.

Present:	Chair M. Hill Hammock, Vice Chair Mary B. Richardson-Lowry and Directors Mary Driscoll, RN, MPH; Ada Mary Gugenheim; Mike Koetting; David Ernesto Munar; Robert G. Reiter, Jr.; and Sidney A. Thomas, MSW (8)
Present Telephonically:	Director Heather M. Prendergast, MD, MS, MPH (1)
Absent:	Directors Hon. Dr. Dennis Deer, LCPC, CCFC and Layla P. Suleiman Gonzalez, PhD, JD (2)

Additional attendees and/or presenters were:

Ekerete Akpan – Chief Financial Officer
Debra Carey – Deputy Chief Executive Officer, Operations
James Kiamos – Chief Executive Officer, CountyCare
Terry Mason, MD – Cook County Department of Public Health
Jeff McCutchan –General Counsel
Iliana Mora – Chief Operating Officer, Ambulatory Services
Beena Peters, DNP, RN, FACHE – Chief Nursing Officer
Carla Salvo – System Manager of Patient Access Financial Counseling
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer

II. Public Speakers

Chair Hammock asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Recommendations, Discussion / Information Items

A. Analysis of the Uninsured (Attachment #1)

Ekerete Akpan, Chief Financial Officer, and Carla Salvo, System Manager of Patient Access Financial Counseling, provided an overview of the presentation on the Analysis of the Uninsured, which included information on the following subjects:

- Introduction and Definitions
- Revenue Cycle – Financial Access and Financial Counseling
  - Departmental Structure
  - Process
  - Overview of Programs
- Payor Mix by Charges FY2016 to Present
- Study and Observations
  - Self-Pay Cohort
  - Charity Care Cohort
  - Observations

III. Recommendations, Discussion / Information Items

A. Analysis of the Uninsured (continued)

During the discussion of the information on the Self-Pay Cohort, Director Munar inquired whether information can be provided regarding the income level of the cohort. Dr. John Jay Shannon, Chief Executive Officer, responded that staff will see if it is available. Additionally, Director Thomas inquired whether diagnostic data can be provided.

B. Strategic Plan FY2020-2022 (Attachment #2)

Dr. Shannon provided an overview of the presentation containing the draft tactics, objectives and highlighted strategies for the strategic plan, and invited Directors to provide any comments and recommendations.

Director Munar stated that more emphasis should be made to improve the payor mix; he recommended that a goal be set. Additionally, he recommended that more emphasis should be made to improve the capitation rate and improve advocacy.

Director Thomas commented that, many years ago, the County commissioned a study on the subject of having Cook County employees receive their health services here at the System. He recalled that there were two (2) issues relating to that: 1) capacity and 2) behavioral health. He stated that there should be more of a focus on behavioral health.

With regard to collective bargaining, Chair Hammock stated that the administration should be sure to identify any work rules that are needed to execute this plan; he would like the administration to report back to the Board where they were successful and not successful in negotiating those.

Director Driscoll requested that a modification be made to Objective 5.1 (slide 26) to read as follows: "Tailor Social Determinant of Health strategies to achieve the most impact on CCH patients and Health Plan members and create health equity."

Director Gugenheim commented that, with regard to Objective 1.1, she believes that there are too many strategies listed; she suggested that some might be collapsed or consolidated under a broader umbrella.

Dr. Shannon stated that the Strategic Plan will be presented to the Board for consideration at the July 26th Board Meeting. The three (3) year financial projections relating to the Strategic Plan will be presented for consideration in August to the Finance Committee and Board. The Strategic Plan and financial projections will then be presented to the County Board for consideration in September.

IV. Adjourn

As the agenda was exhausted, Chair Hammock declared that the meeting was ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXX
M. Hill Hammock, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

CCH Uninsured Study 2016 – 2018
Preliminary Observations

Ekerete Akpan, Chief Financial Officer

July 18, 2019

COOK COUNTY HEALTH

Agenda

1. Introduction and definitions
2. Revenue Cycle - Financial Access and Financial Counseling
    a. Departmental Structure
    b. Process
    c. Overview of programs
3. Payor Mix by Charges FY 2016 to Present
4. Study and Observations
    a. Self-Pay cohort
    b. Charity Care cohort
    c. Observations

Introduction / Definition of Terms

COOK COUNTY HEALTH

Uninsured

42 CFR Part 447 – for Disproportionate Share Hospitals (DSH) purposes describes uninsured individuals as those "who have no health insurance (or other source of third party coverage) for the services furnished during the year." Also, "who have health insurance (or other third party coverage)" to refer broadly to individuals "who have creditable coverage consistent with the definitions under 45 CFR parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer".

Uninsured (based on the 2018 health survey interview)

1. Number of persons under age 65 uninsured at the time of interview - 30.1 million
2. Percent of persons under age 65 uninsured at the time of interview - 11.1%
3. Percent of children under age 18 uninsured at the time of interview - 5.2%
4. Percent of adults aged 18-64 uninsured at the time of interview - 13.3% [1]

Source https://www.cdc.gov/nchs/fastats/health-insurance.htm

Underinsured and Self-Pay

Underinsured Patients

Patients that have insurance, but the insurance doesn't cover the cost of healthcare. Commonwealth Fund further defines as, "individuals insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty"

- **CCH CareLink** defined as a CCH patients covered by a private health insurance plan that has an active contract with CCH as an in-network provider. Patients with an HMO plan contracted with CCH AND who select CCH to serve as their Primary Care Provider, or patients with a PPO plan or traditional "fee-for-service, may apply for CareLink and receive a discount on the out-of-pocket costs associated with these plans, including deductibles and co-insurance. CareLink cost-sharing fees would be applicable.

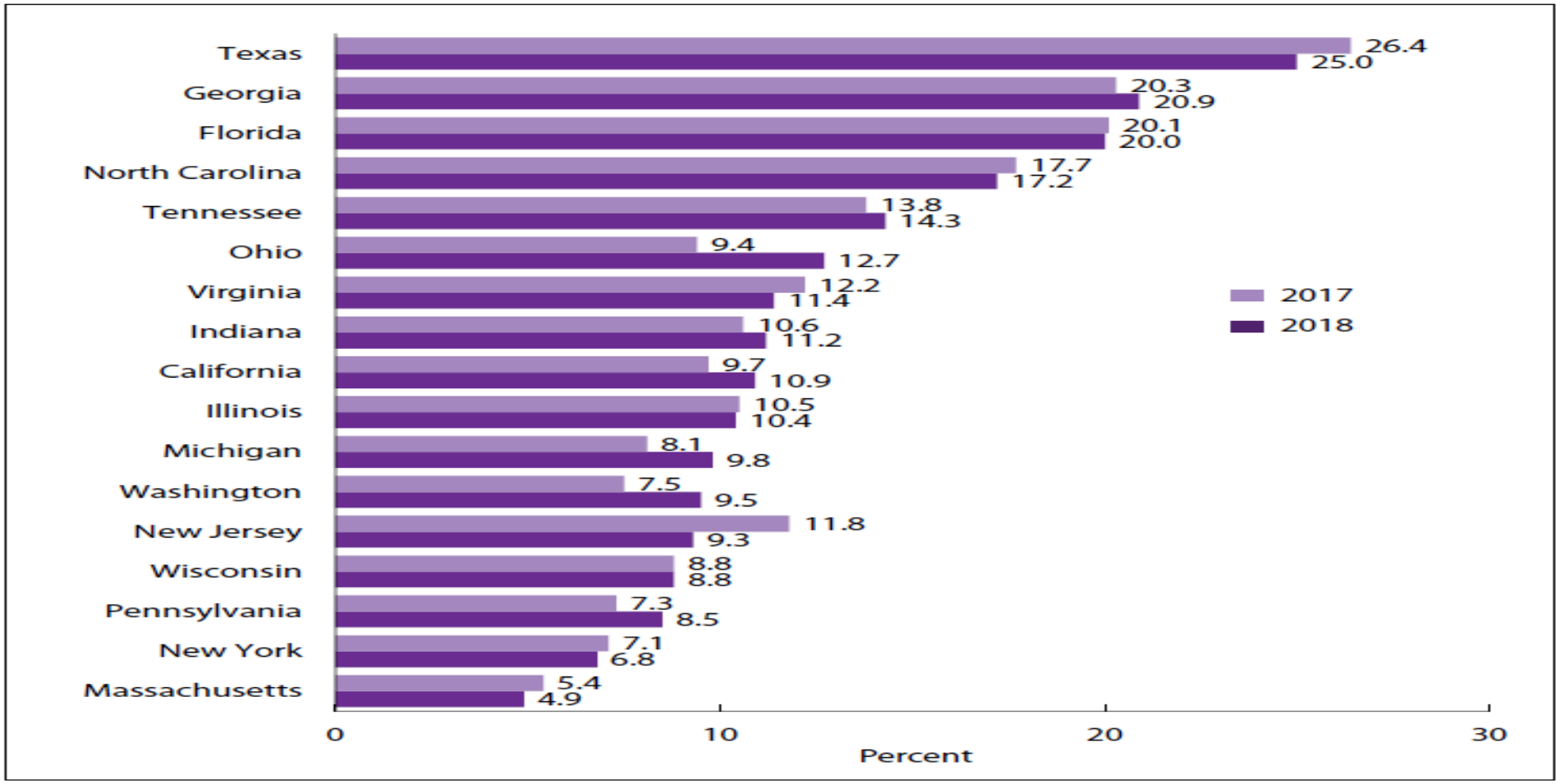
Self Pay Patients

Patients that have no insurance and pay out of pocket, or patients that owe a balance after insurance payments

Data source: March 2011, 2012, and 2013 Current Population Surveys.

Uninsured : US and State of Illinois

Figure 12. Percentage of adults aged 18–64 who were uninsured at the time of interview, by selected state and year: United States, 2017 and 2018



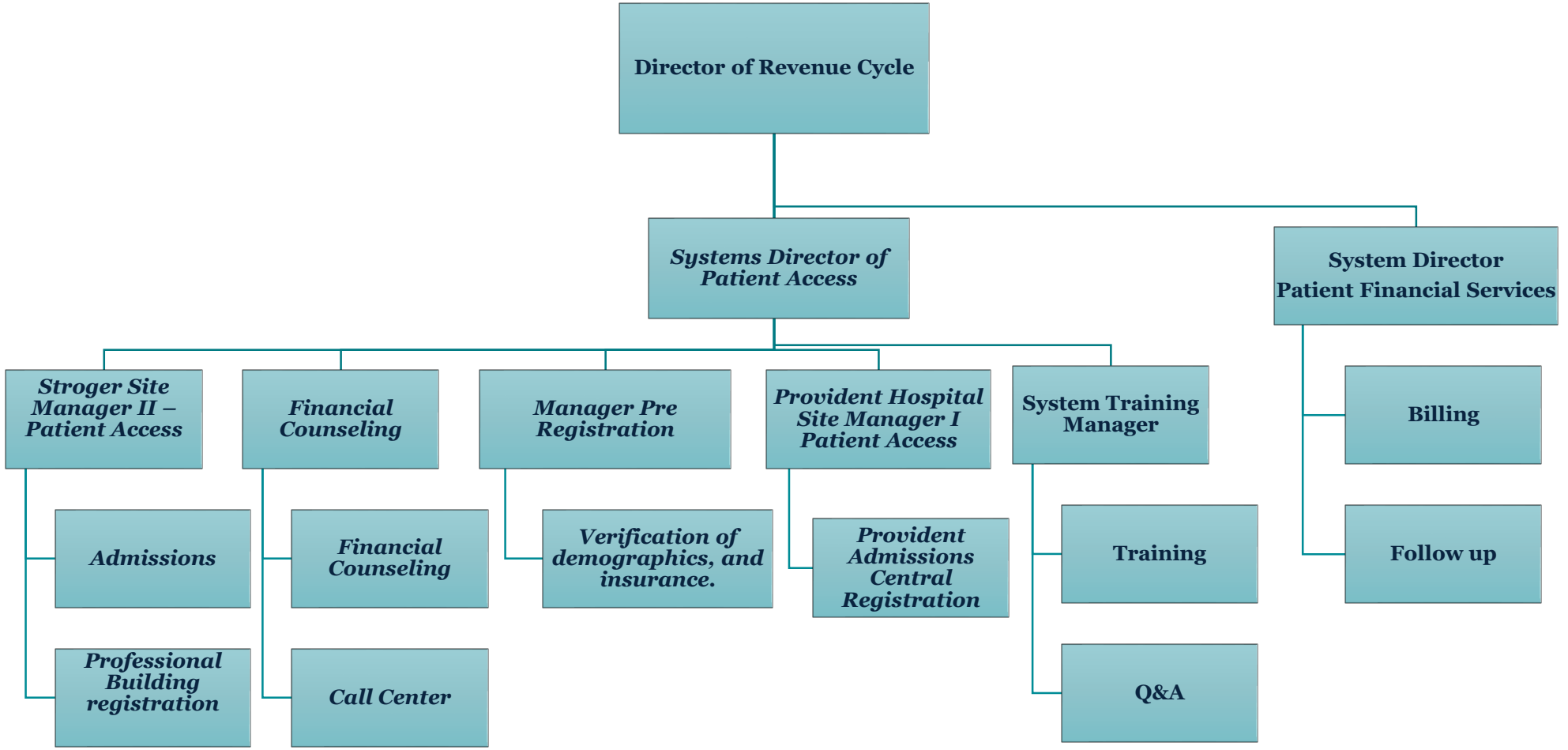
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2017 and 2018, Family Core component.

Data source: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf

Revenue Cycle - Patient Access & Financial Counseling

COOK COUNTY HEALTH

Overview of Revenue Cycle Department



Overview of Revenue Cycle Department

Areas of Responsibility and Scale of Operations

Department Name	Budget	FTE	Contracts
Revenue Cycle Patient Access • Call Center • Admissions • Financial Counseling • Systems Training and Quality Patent Financial Services • Billing • Follow-up	**$18M**	**304**	Ajilon **$195K** Great Lakes Medicaid (GLM) **$1.7M** Change Healthcare **$334K** Experian **$400K**

Financial Counseling - Benefits Advisory Services

1. Financial Counseling - Benefits Advisors
   - ✓ Advise and educate patients on the best benefits and payment options for medical charges incurred during visits.

2. Purpose / Citation -
   - ✓ Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010
   - ✓ Cook County Ordinance (No. 16-4392,9-14-2016) enhancing CCH Financial Assistance (Direct Access) program

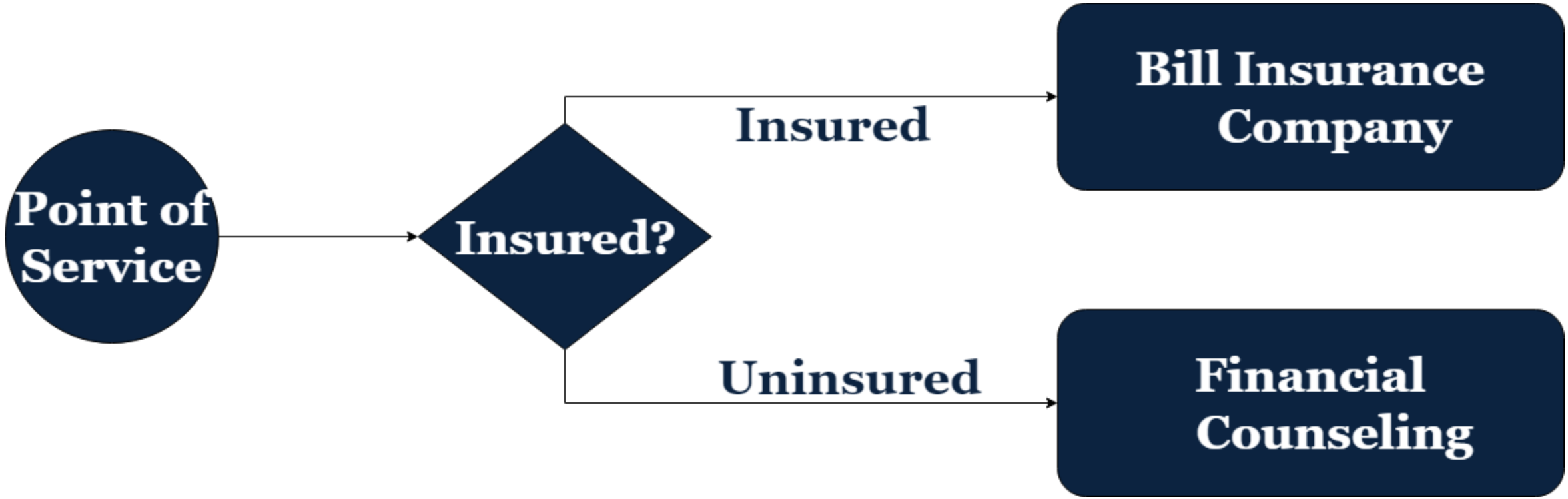
1. https://www.healthcare.gov/glossary/affordable-care-act/
2.http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3001&ChapterID=21
3. https://www.cms.gov/regulations-and-guidance/legislation/emtala/

Financial Counselling - Benefits Advisory Services

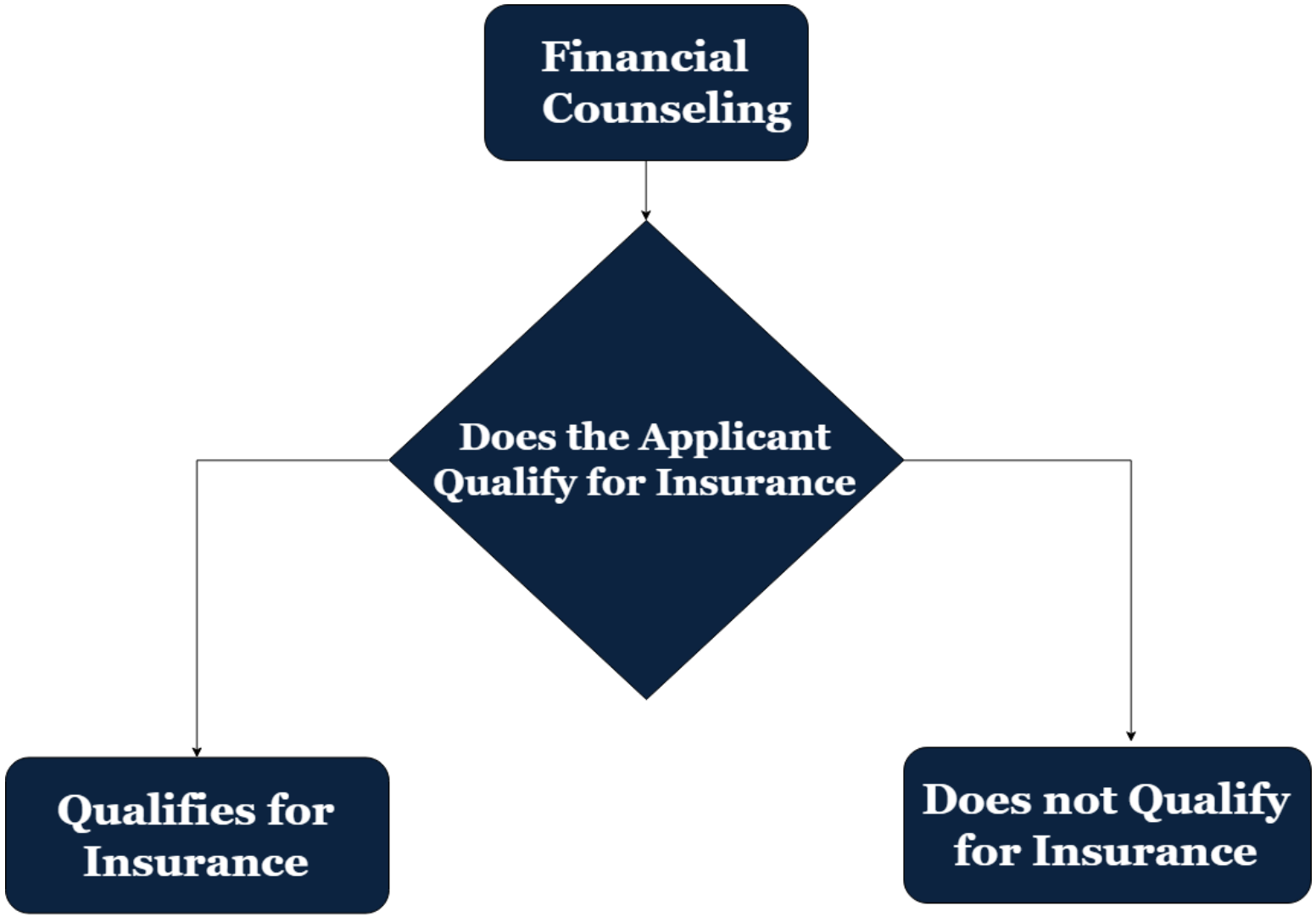
1. **Purpose / Citation - cntd.**
   - ✓ **Financial Assistance Policies (FAPs). Section 501(r)(4) of the Internal Revenue Code (IRC) requires a tax-exempt hospital organization to establish a written financial assistance policy (FAP).**
     - ✓ **Section 9007(a) of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 (124 Stat. 119 (2010)).**
     - ✓ **TD 9708, 79 FR 78954, Internal Revenue Service, New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act**
     - ✓ **Internal Revenue Service, Tax Exempt Hospitals: The Community Benefit Standard and Affordable Care Act under IRC Section 501(r), Financial Assistance Policy.**
   - ✓ **Hospital Uninsured Patient Discount Act of Illinois (HUPDA) – A discount program established to help residents living in the State of Illinois (but outside of Cook County) who are uninsured to pay for their health care services at CCH.** [2]
   - ✓ **Emergency Medical Treatment and Active Labor Act (EMTALA) – To ensure public access to emergency services regardless of ability to pay.** [3]

1. https://www.healthcare.gov/glossary/affordable-care-act/
2. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3001&ChapterID=21
3. https://www.cms.gov/regulations-and-guidance/legislation/emtala/

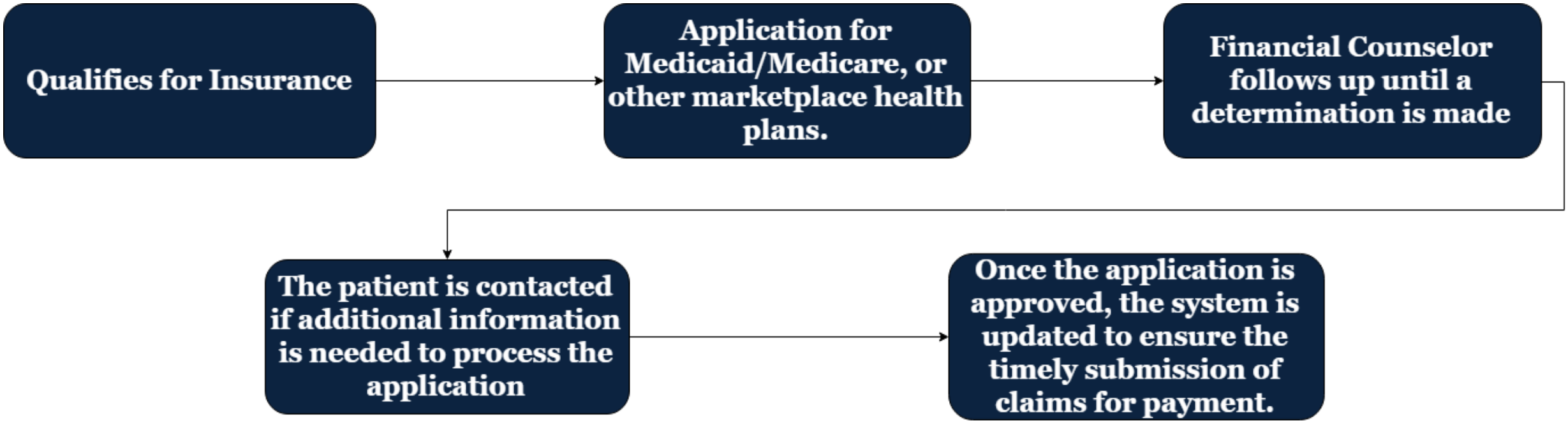
Financial Counseling Process (Flow Chart)



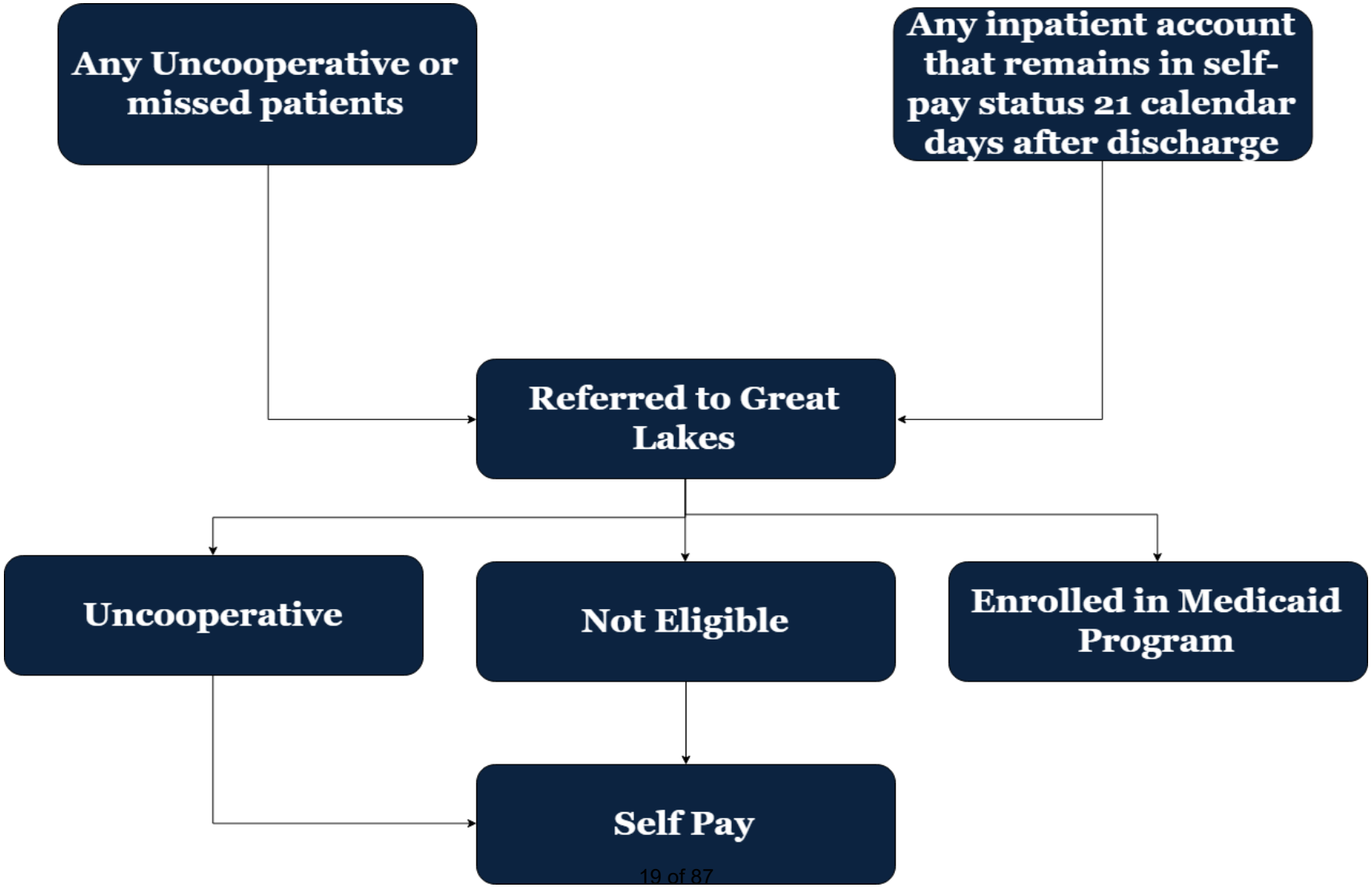
Financial Counseling Process (Flow Chart)



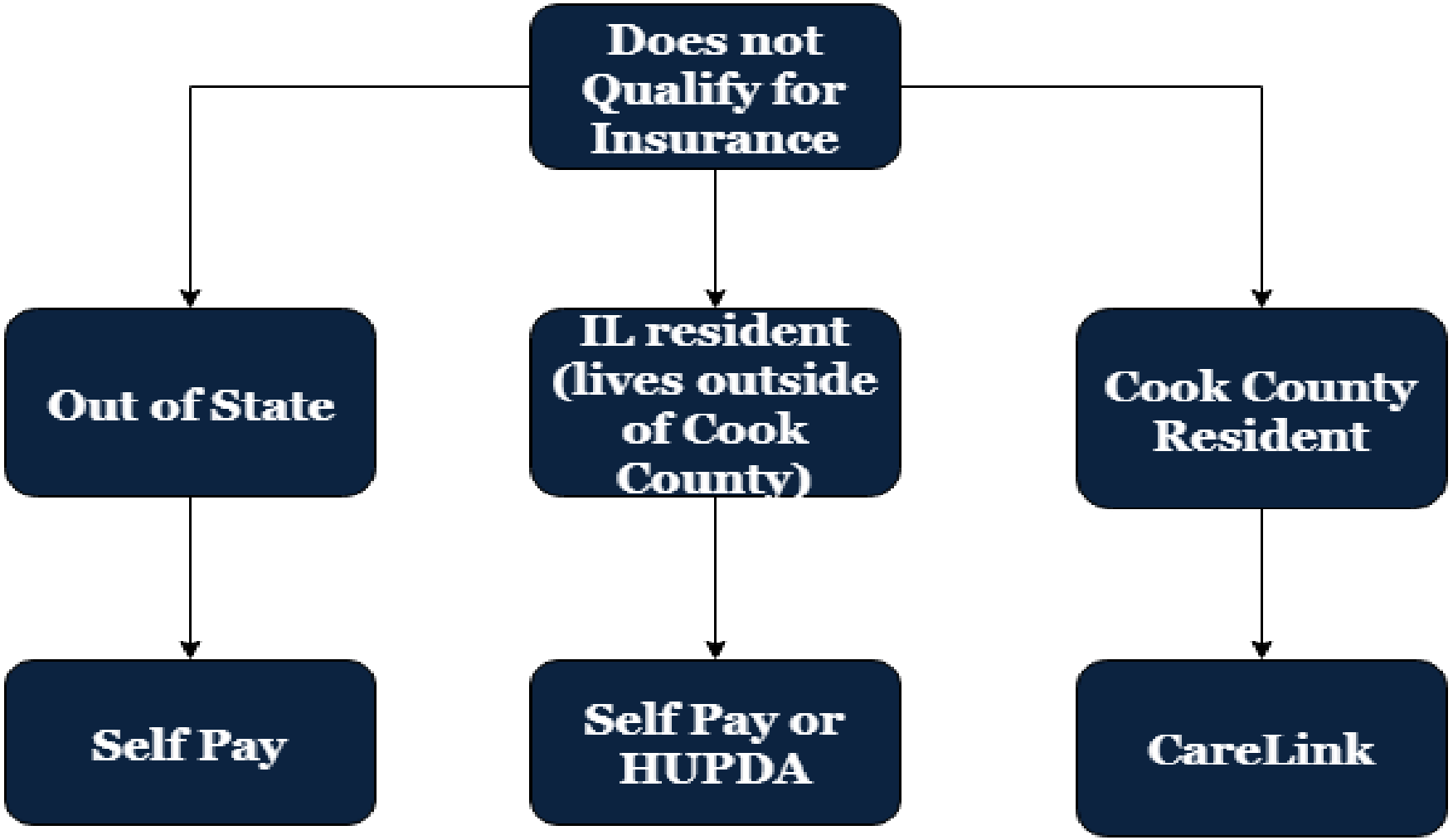
Financial Counseling Process (Flow Chart)



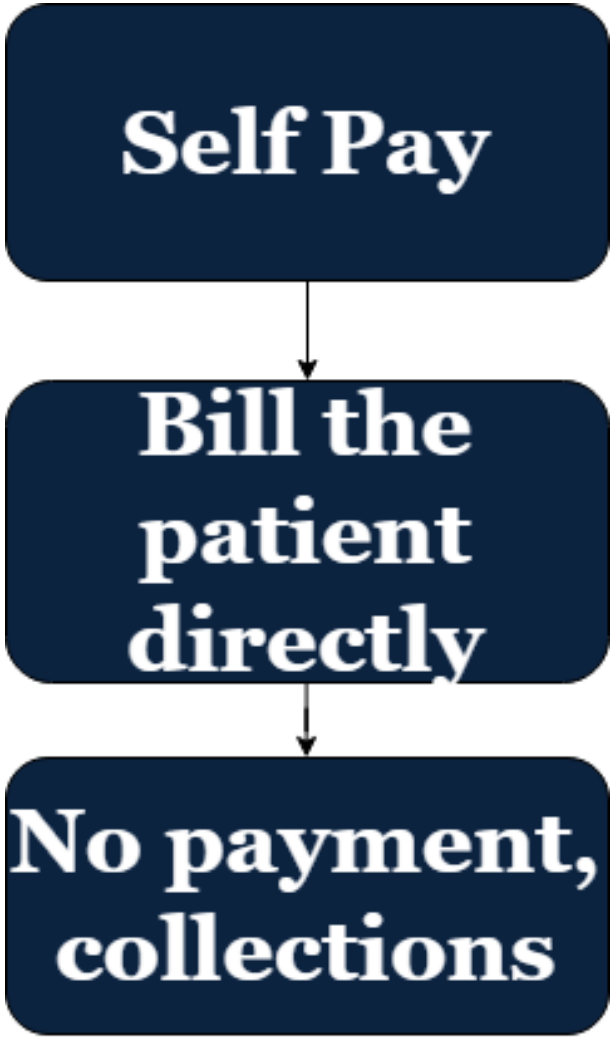
Financial Counseling Process (Flow Chart)



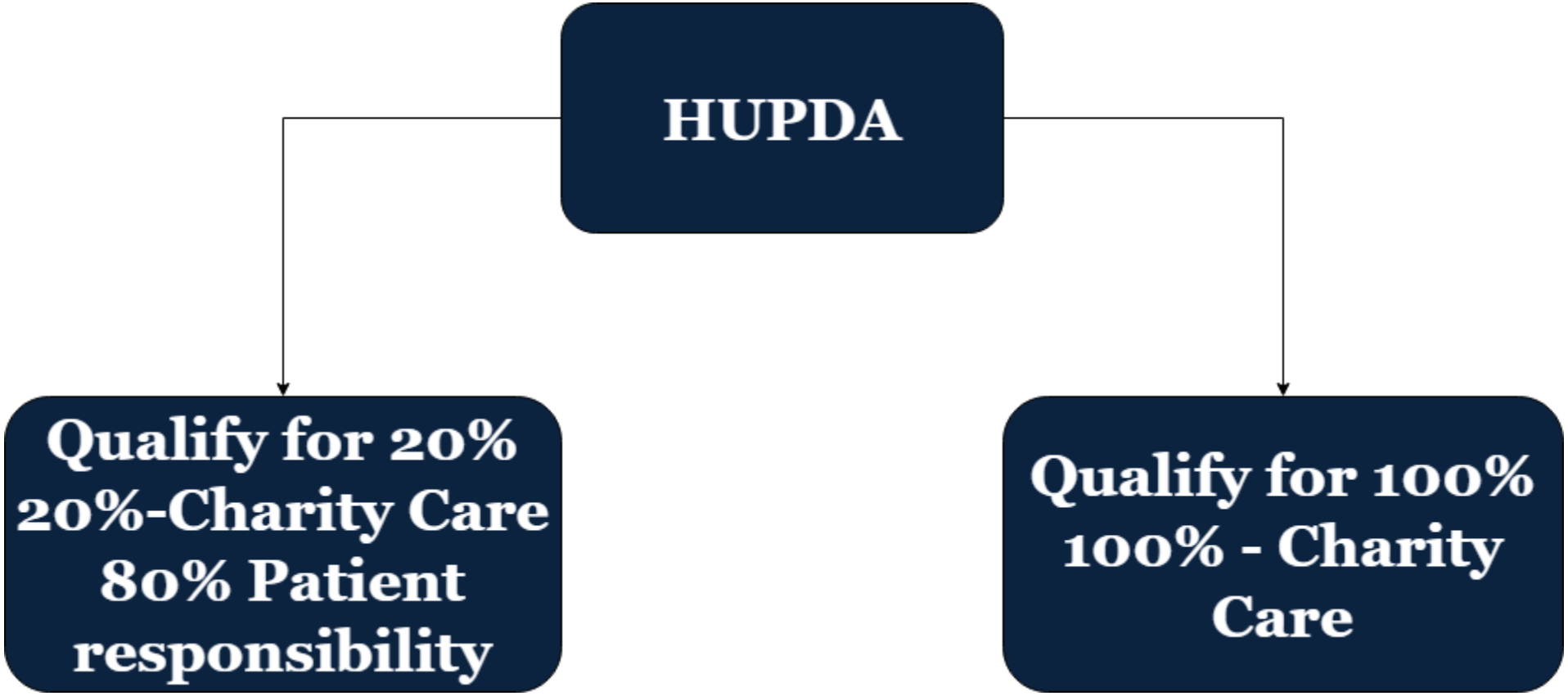
Financial Counseling Process (Flow Chart)



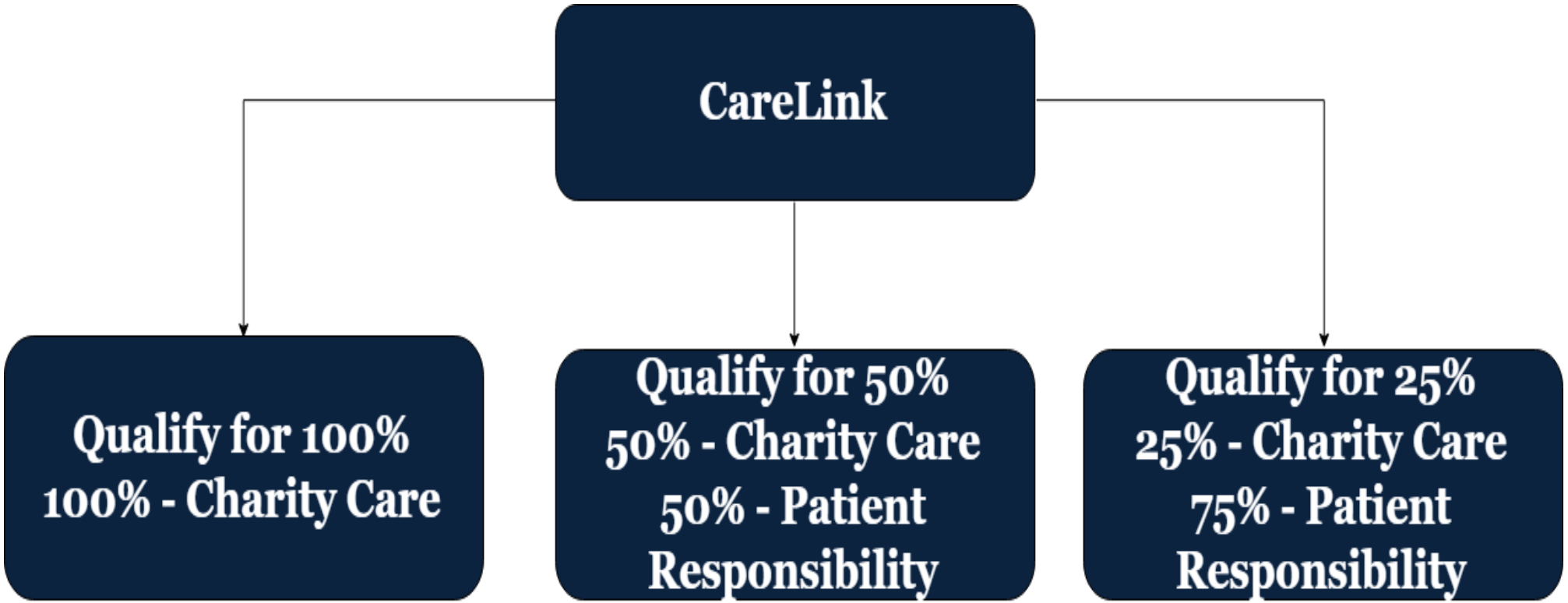
Financial Counseling Process (Flow Chart)



Financial Counseling Process (Flow Chart)



Financial Counseling Process (Flow Chart)



Program Overview: ACA - Medicaid Expansion

ACA Medicaid expansion approval levels are based on the Federal Poverty Level (FPL) guidelines

- Income less than or equal to 138%

Family Size	Monthly	Yearly
1	$1,436	**$17,232**
2	$1,944	**$23,328**

****Effective Date: 4/1/2019***

Program Overview: CareLink Approval Levels

CareLink approval levels are based on the Federal Poverty Level (FPL) guidelines

- Income less than or equal to 250% FPL = 100% CareLink discount
- Income greater than 250% FPL but less than 350% FPL = 50% CareLink discount
- Income greater than 350% FPL but less than 600% = 25%

Updated as of 4/1/2019

Family Size	Maximum yearly income	Maximum yearly income	Maximum yearly income
	100% Discount	50% Discount	25% Discount
1	$31,225	$43,715	$74,940
2	$42,275	$59,185	$101,460
3	$53,325	$74,655	$127,980
4	$64,375	$90,125	$154,500

Program Overview: Hospital Uninsured Patient Discount Act Approval Levels

HUPDA approval levels are based on the Federal Poverty Level (FPL) guidelines

- Income less than or equal to 200% = 100% discount

- Income greater than 200% FPL = 20% discount

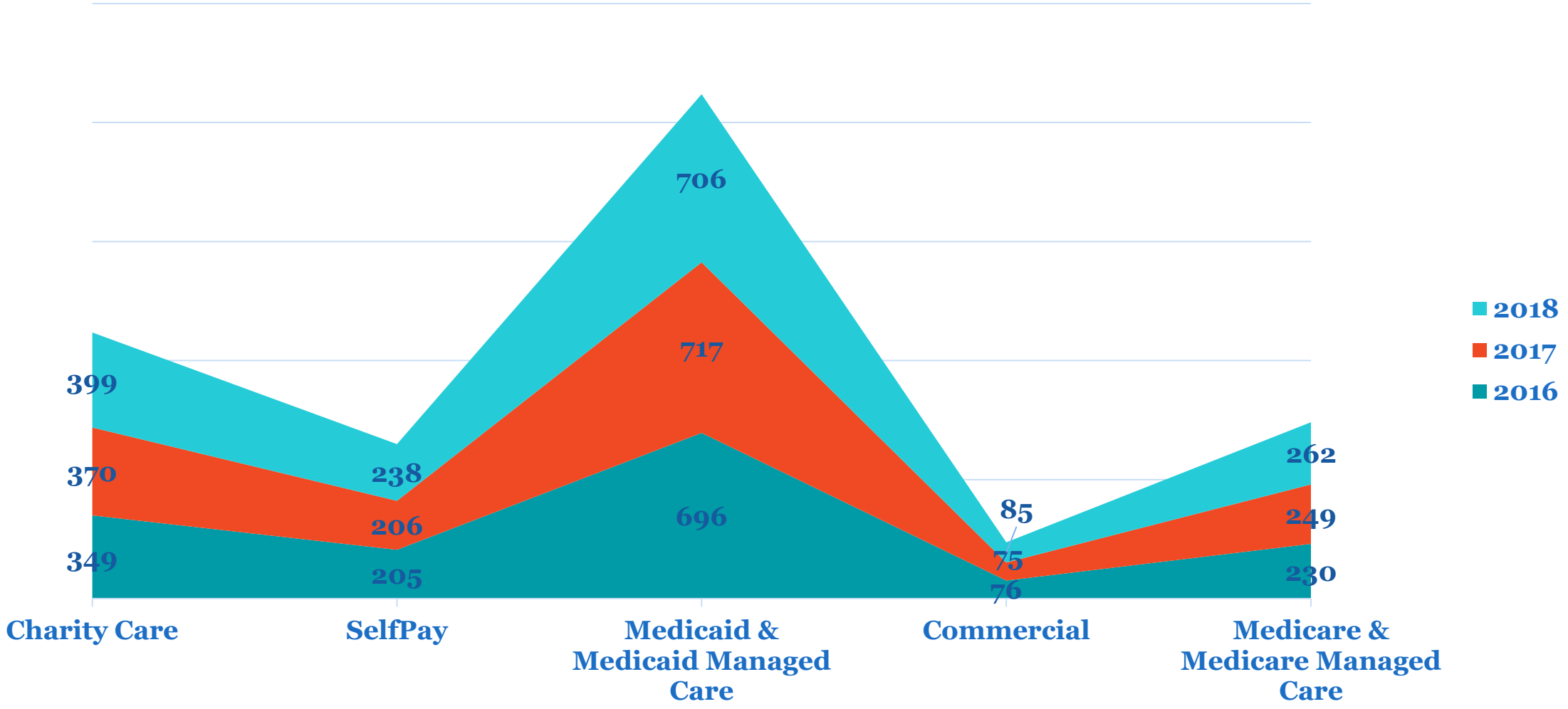
Effective 4/1/19

Family Size	100% Discount	20%
1	$24,980	$74,940
2	$33,820	$101,460
3	$42,660	$127,980
4	$51,500	$154,500
5	$60,340	$181,020
6	$69,180	$207,540
7	$78,020	$234,060
8	$86,860	$260,580

FY 2016 through FY 2019 YTD
Payor Mix by Charges

COOK COUNTY HEALTH

System Payor Mix By Charges FY2016-FY2018 (in millions)



Uninsured Analysis Study and Preliminary Observations

COOK COUNTY HEALTH

Uninsured Analysis

1. Process of Study
   - ✓ Point in time Cohort Study of uninsured patients in the self-pay and Charity Care category
   - ✓ FY2018 cohort looking back through FY2016
   - ✓ FY2016 cohort looking forward through FY2018
2. Results & Observations
   - ✓ Demographics
   - ✓ Location
   - ✓ Utilization vs Rest of CCH
   - ✓ Utilization

Uninsured Analysis Methodology

1. Cohort of ALL uninsured on a certain day 11/30/2018 was identified.
2. Identified patients in cohort was queried to determine if members were also ;
    a. uninsured on 11/30/2017 and,
    b. uninsured on 11/30/2016
3. Results - 22,228 patients were identified as continuously uninsured Patients in FY2016 through FY2018
        a. 6,990 were identified as Self Pay
        b. 15,238 were identified as Charity Care

Uninsured Analysis – Study Questions

1. Does CCH have a robust Benefits Advisory/Financial Counseling process for connecting eligible patients to benefits?
2. How many consistently uninsured do we serve?
3. Who are the consistently uninsured, i.e. demographics?
4. Do the consistently uninsured have problems in accessing CCH services vs the rest of CCH?
5. What are financial implications for CCH serving the continuously uninsured?

Self Pay Cohort

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Self Pay Cohort

1. Definition / Process of Study
   - ✓ Point in time Cohort Study of Self-Pay patients
   - ✓ FY2018 cohort looking back through FY2016
   - ✓ FY2016 cohort looking forward through FY2018
2. Results & Observations vs Kaiser Family Foundation Study key Facts
   - ✓ Demographics
   - ✓ Location
   - ✓ Utilization vs Rest of CCH
   - ✓ Utilization

Self Pay Cohort – Summary of Results
Observations vs. Kaiser Family Foundation (KFF) Key Facts

How many people are Self-Pay? - 6,990

Why do people remain Self-Pay? – To be tested or surveyed

KFF Research Findings - In 2017, 45% of uninsured adults said that they remained uninsured because

- the cost of coverage was too high.
- many do not have access to coverage through a job
- some eligible for financial assistance under the ACA may not know they can get help,
- and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

3. Who remains in Self Pay? Male (52%) White (46%)

45-64 years old (47%) non Hispanic/Latino (52%)

Self Pay Cohort - Summary of Results
Observations vs. Kaiser Family Foundation Key Facts

How does not having coverage affect health care access?

7% more Visits, 9% more outpatient visits, about 13% less inpatient stays.

A. **People without insurance coverage have worse access to care than people who are insured?**

Not apparent in CCH population

B. **Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.**

To be further interrogated

What are financial implications for CCH serving the continuously uninsured?

CCH FY2018 - 235K Accounts referred to collections, $296.8M and $3.7M or 1% Collected

Per KFF - The uninsured often face unaffordable medical bills when they do seek care. In 2017, uninsured nonelderly adults were over twice as likely as their insured counterparts to have had problems paying medical bills in the past 12 months. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

Self Pay Charges -Top 15 Services by Charges (in millions $'s)

Clinical Service	2016	2017	2018	Grand Total
EMERGENCY ADULT	$ 38.95	$ 35.52	$ 48.38	$ 122.85
GEN MED	$ 35.88	$ 34.50	$ 35.63	$ 106.00
AMBULATORY SURG	$ 22.79	$ 20.19	$ 24.92	$ 67.90
MEDICINE	$ 11.97	$ 14.28	$ 16.98	$ 43.23
TRAUMA	$ 10.12	$ 9.86	$ 11.33	$ 31.30
FAMILY PRACTICE	$ 6.41	$ 7.95	$ 7.51	$ 21.87
SURGERY	$ 6.54	$ 4.86	$ 6.18	$ 17.58
OBSTETRICS	$ 3.38	$ 6.92	$ 4.82	$ 15.12
CHEMOTHERAPY	$ 4.55	$ 4.96	$ 4.89	$ 14.40
RADIATION THERAPY	$ 4.73	$ 4.64	$ 4.60	$ 13.97
GYNECOLOGY	$ 3.25	$ 3.09	$ 4.48	$ 10.82
CARDIOTHORACIC SURGERY	$ 4.20	$ 3.44	$ 2.75	$ 10.39
OPHTHALMOLOGY	$ 2.77	$ 3.50	$ 4.10	$ 10.38
UROLOGY	$ 2.76	$ 3.14	$ 2.84	$ 8.74
NEUROSURGERY	$ 2.85	$ 2.68	$ 2.32	$ 7.84
All Others				
Grand Total				

Self Pay Demographics

	Self Pay	
Gender	**Patients**	**Percent**
Female	3,358	48.0%
Male	3,626	51.9%
Transgender	6	0.1%
Total	6,990	
	Self Pay	
Race	**Patients**	**Percent**
African-American/Black	2,450	35.1%
American Indian/Native Alaskan	131	1.9%
Asian	380	5.4%
Native Hawaiian/Pacific Islander	3	0.0%
Other/UTD	783	11.2%
White	3,243	46.4%
	Self Pay	
Ethnicity	**Patients**	**Percent**
Hispanic/Latino/Spanish Origin	3,320	47.5%
Non-Hispanic/Latino/Spanish Origin	3,669	52.5%
Unknown	1	0.0%
	Self Pay	
Age Group	**Patients**	**Percent**
0 - 18	82	1.2%
19 - 44	2,836	40.6%
45 - 64	3,282	47.0%
65 - 74	568	8.1%
75 +	222	3.2%

Self Pay Location – Widely Distributed

Self Pay			
Zip Code	Patients	Percent	Cumulative
60608	471	6.7%	6.7%
60623	367	5.3%	12.0%
60629	325	4.6%	16.6%
60804	297	4.2%	20.9%
60632	284	4.1%	24.9%
60609	239	3.4%	28.4%
60639	233	3.3%	31.7%
60617	166	2.4%	34.1%
60651	159	2.3%	36.4%
60625	135	1.9%	38.3%
60628	126	1.8%	40.1%
60618	124	1.8%	41.9%
60620	122	1.7%	43.6%
60619	118	1.7%	45.3%
60636	117	1.7%	47.0%
Rest	3,707	53.0%	100.0%

Self Pay Utilization (Total Visits)

Self Pay			
Total Visits	Patients	Percent	Cumulative
1	1,802	25.8%	25.8%
2	1,121	16.0%	41.8%
3	819	11.7%	53.5%
4	649	9.3%	62.8%
5	536	7.7%	70.5%
6	383	5.5%	76.0%
7	300	4.3%	80.3%
8	222	3.2%	83.4%
9	184	2.6%	86.1%
10	151	2.2%	88.2%
> 10	823	11.8%	100.0%

Self Pay			
Number of patients with only 1 visit to Emergency			
ED Visits		Patients	Percent
1		679	9.7%

Utilization Rates per 1,000 patients		
	Self Pay	Everyone Else
Total Visits	5,018	4,687
Outpatient	**4,253**	**3,886**
E.D Discharged	638	641
Total Admissions	110	141
Inpatient	60	89
Observation	50	52

Charity Care Cohort

COOK COUNTY HEALTH

Charity Care Cohort

1. Definition / Process of Study
   - ✓ Point in time Cohort Study of uninsured patients
   - ✓ FY2018 cohort looking back through FY2016
   - ✓ FY2016 cohort looking forward through FY2018
2. Results & Observations
   - ✓ Demographics
   - ✓ Location
   - ✓ Utilization vs Rest of CCH
   - ✓ Utilization

Charity Care Cohort – Summary of Results / Observations vs Kaiser Family Foundation (KFF) Key Facts

How many people are continuously in Charity Care? - 15,238

Why do people remain Charity Care? – To be tested or surveyed

KFF Research Findings - In 2017, 45% of uninsured adults said that they remained uninsured because

- the cost of coverage was too high.
- Many people do not have access to coverage through a job, and some people
- Some people who are eligible for financial assistance under the ACA may not know they can get help,
- and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

3. Who (demographics) remains in Charity care? - Female 64% White 71%

Age (45-64) making up 56% non Hispanic/Latino 73%

Charity Care Cohort – Summary of Results
Observations vs. Kaiser Family Foundation Key Facts

1. Quick Summary of Results

How does not having coverage affect health care access? 99% more Visits , 122% more outpatient visits, about 21% more observation stays

A. People without insurance coverage have worse access to care than people who are insured?

Not apparent in CCH population

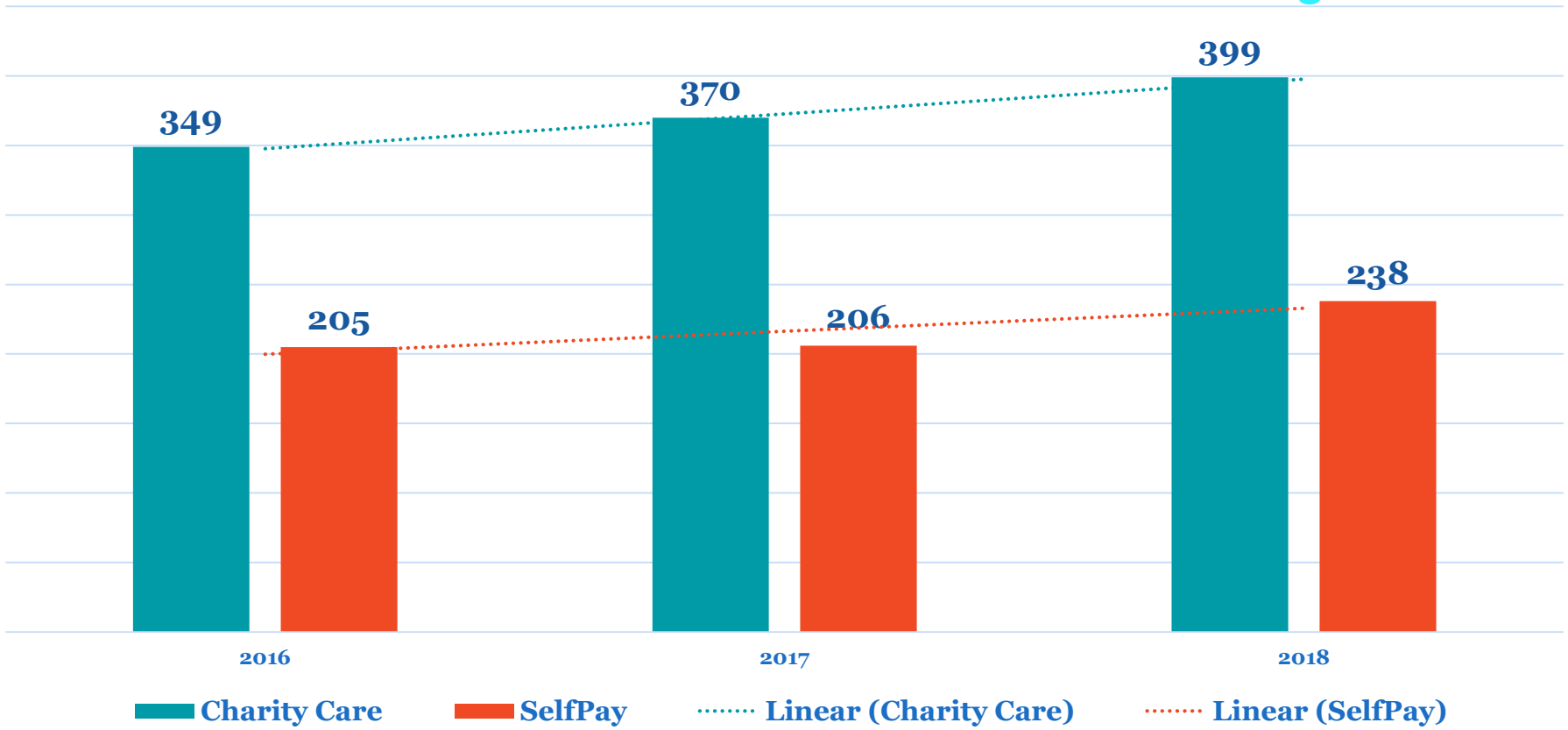
B. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

To be further interrogated

What are financial implications for CCH serving the continuously uninsured?

Charity Care Cohort – Summary of Results
Observations vs. Kaiser Family Foundation Key Facts

What are financial implications for CCH serving the uninsured? Data below - Charges in $ millions



Charity Care- Top 15 Services by Charges (in millions $'s)

Services	2016	2017	2018	Grand Total
GEN MED	51.02	59.93	47.99	158.95
AMBULATORY SURG	42.22	49.14	49.85	141.21
EMERGENCY ADULT	22.87	21.75	27.59	72.21
MEDICINE	21.03	24.65	26.18	71.85
FAMILY PRACTICE	15.52	22.16	24.29	61.96
SURGERY	13.33	14.20	16.29	43.82
GYNECOLOGY	12.36	12.64	16.29	41.30
RADIATION THERA	13.01	11.37	16.90	41.27
CHEMOTHERAPY	12.47	14.00	14.29	40.76
OPHTHALMOLOGY	6.17	8.53	9.81	24.51
CARDIOTHORACIC SURGERY	6.81	6.76	9.68	23.26
LABORATORY	7.67	7.01	6.32	21.00
RADIOLOGY (GENE	3.50	6.31	10.14	19.95
RADIOLOGY IMAGI	8.21	6.35	4.27	18.83
NEUROSURGERY	5.13	5.86	5.94	16.93

Charity Care Demographics

	Carelink/Financial Assist	
Gender	**Patients**	**Percent**
Female	9,701	63.7%
Male	5,532	36.3%
Transgender	5	0.0%
Total	15,238	
	Carelink/Financial Assist	
Race	**Patients**	**Percent**
African-American/Black	1,163	7.6%
American Indian/Native Alaskan	226	1.5%
Asian	1,089	7.1%
Native Hawaiian/Pacific Islander	11	0.1%
Other/UTD	1,909	12.5%
White	10,840	71.1%
	Carelink/Financial Assist	
Ethnicity	**Patients**	**Percent**
Hispanic/Latino/Spanish Origin	11,139	73.1%
Non-Hispanic/Latino/Spanish Origin	4,099	26.9%
Unknown	0	0.0%
	Carelink/Financial Assist	
Age Group	**Patients**	**Percent**
0 - 18	0	0.0%
19 - 44	4,550	29.9%
45 - 64	8,465	55.6%
65 - 74	1,705	11.2%
75 +	518	3.4%

Charity Care Location

Carelink/Financial Assist			
Zip Code	Patients	Percent	Cumulative
60804	1,058	6.9%	6.9%
60629	1,013	6.6%	13.6%
60623	957	6.3%	19.9%
60632	941	6.2%	26.0%
60639	765	5.0%	31.1%
60609	473	3.1%	34.2%
60641	425	2.8%	37.0%
60608	418	2.7%	39.7%
60625	371	2.4%	42.1%
60618	343	2.3%	44.4%
60411	335	2.2%	46.6%
60634	315	2.1%	48.7%
60402	287	1.9%	50.5%
60074	266	1.7%	52.3%
60617	261	1.7%	54.0%
Rest	7,010	46.0%	100.0%

Charity Care Utilization (Total Visits)

Carelink/Financial Assist			
Total Visits	Patients	Percent	Cumulative
1	1,099	7.2%	7.2%
2	1,247	8.2%	15.4%
3	1,229	8.1%	23.5%
4	1,217	8.0%	31.4%
5	1,227	8.1%	39.5%
6	1,164	7.6%	47.1%
7	1,022	6.7%	53.8%
8	884	5.8%	59.6%
9	824	5.4%	65.1%
10	686	4.5%	69.6%
> 10	4,639	30.4%	100.0%

Utilization Rates per 1,000 patients		
	Carelink/Financial Assist	Everyone Else
Total Visits	9,328	4,687
Outpatient	**8,631**	**3,886**
E.D Discharged	532	641
Total Admissions	148	141
Inpatient	85	89
Observation	63	52

Carelink/Financial Assist			
Number of patients with only 1 visit to Emergency			
ED Visits		Patients	Percent
1		213	1.4%

Final Observations/Questions

1. Does our process work?
    1. Culture?
    2. Practices?
    3. Improvements?

2. Have we done all we can or should do for these groups?
3. Are their utilization patterns different?
4. Other Questions?

Questions?

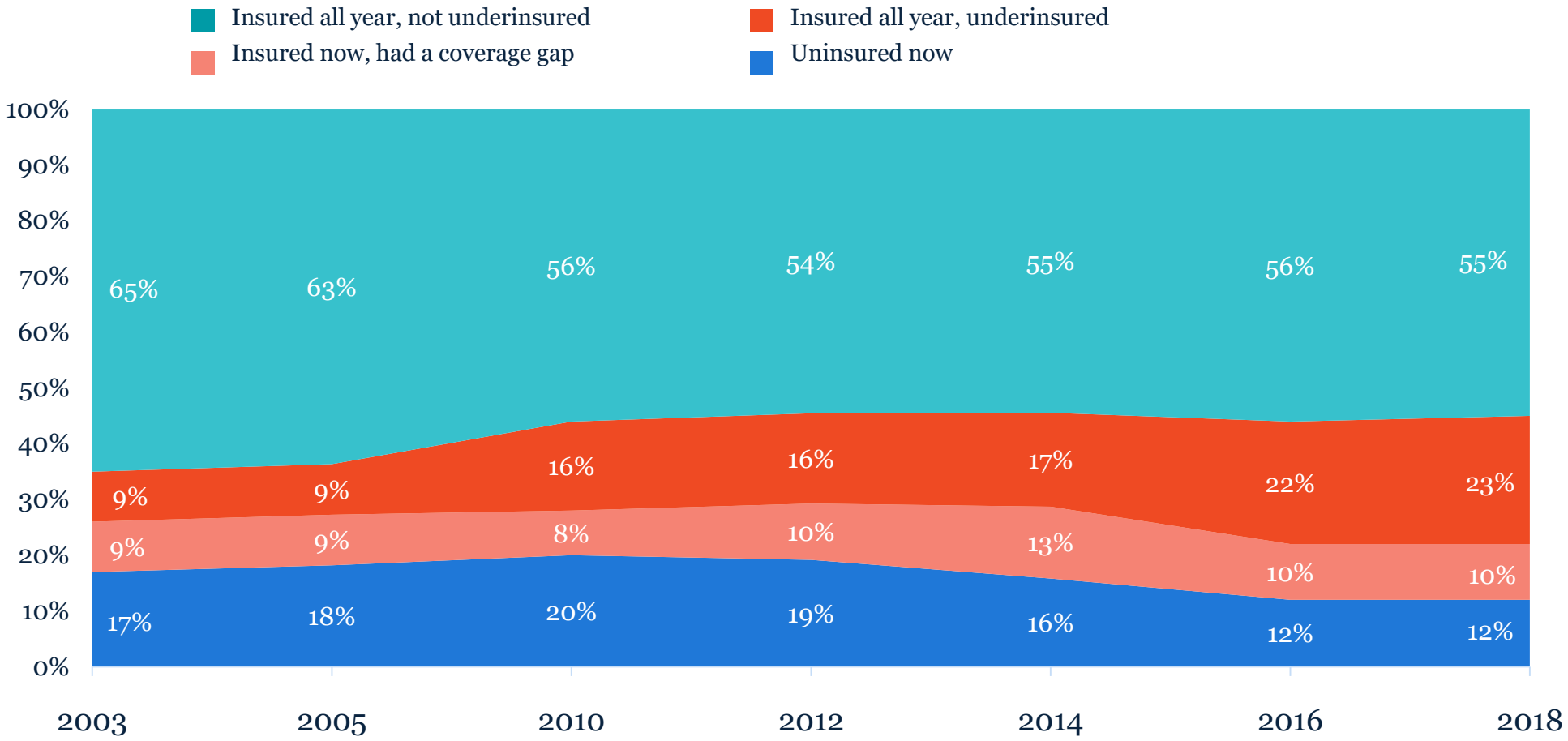
COOK COUNTY HEALTH

Appendix?

COOK COUNTY HEALTH

Since the ACA, Fewer Adults Are Uninsured, but More Are Underinsured

Percent of adults ages 19–64



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

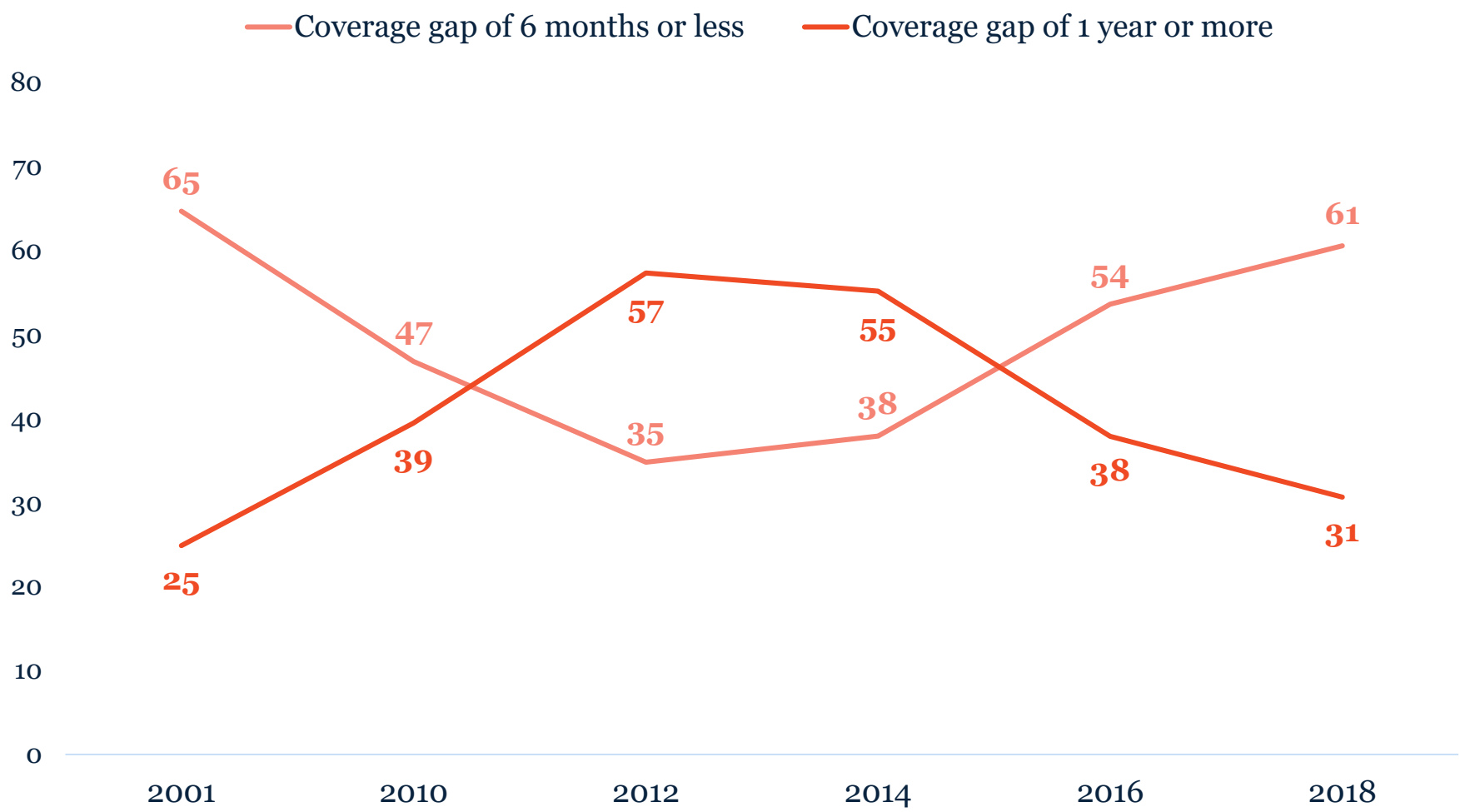
Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

The Commonwealth Fund

Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

Since the ACA, Gaps in People's Coverage Have Been Shorter

Percent of adults ages 19–64 insured now but had a coverage gap in past year

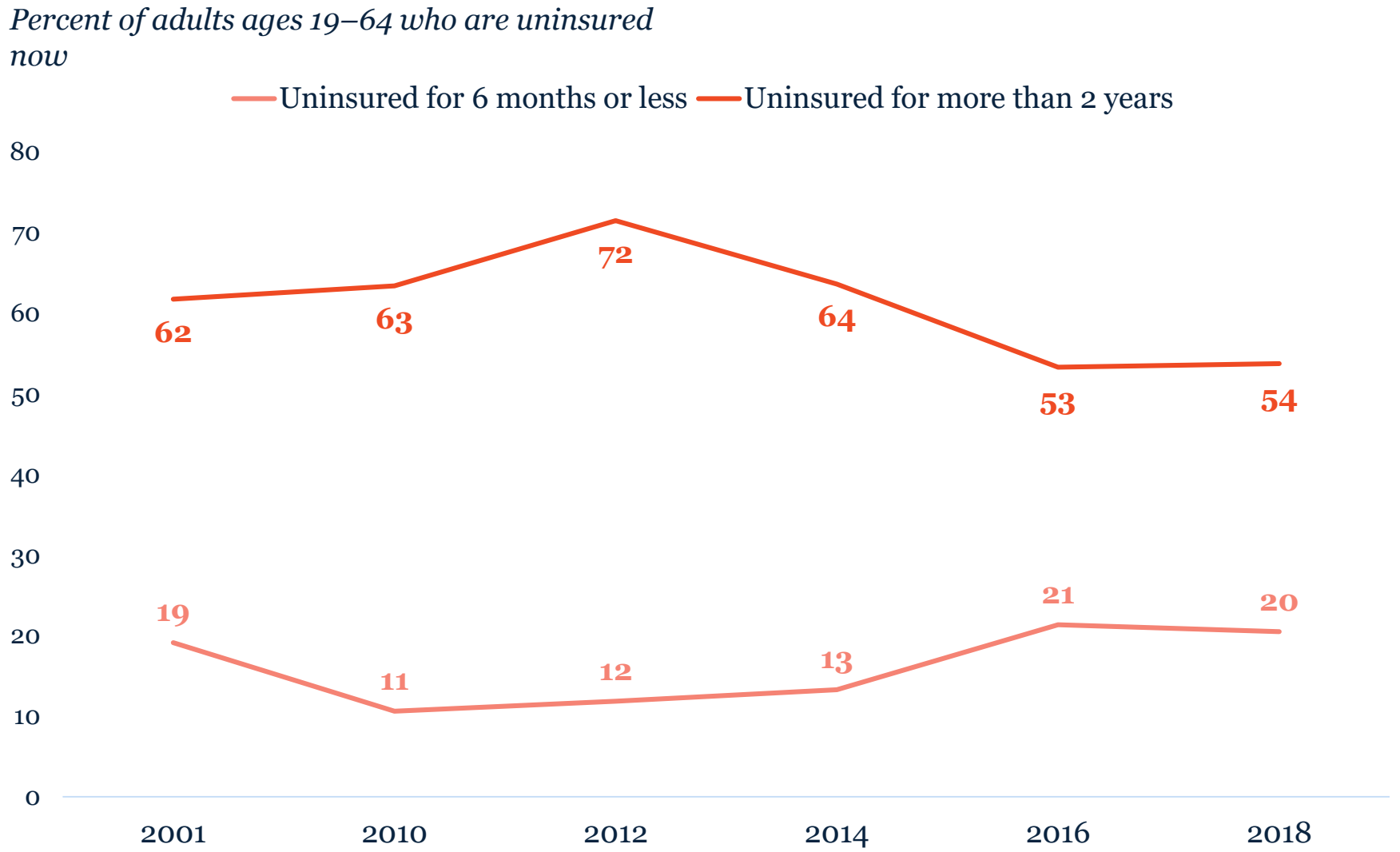


Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).

The Commonwealth Fund

Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

There Has Been Some Improvement in Long-Term Uninsured Rates



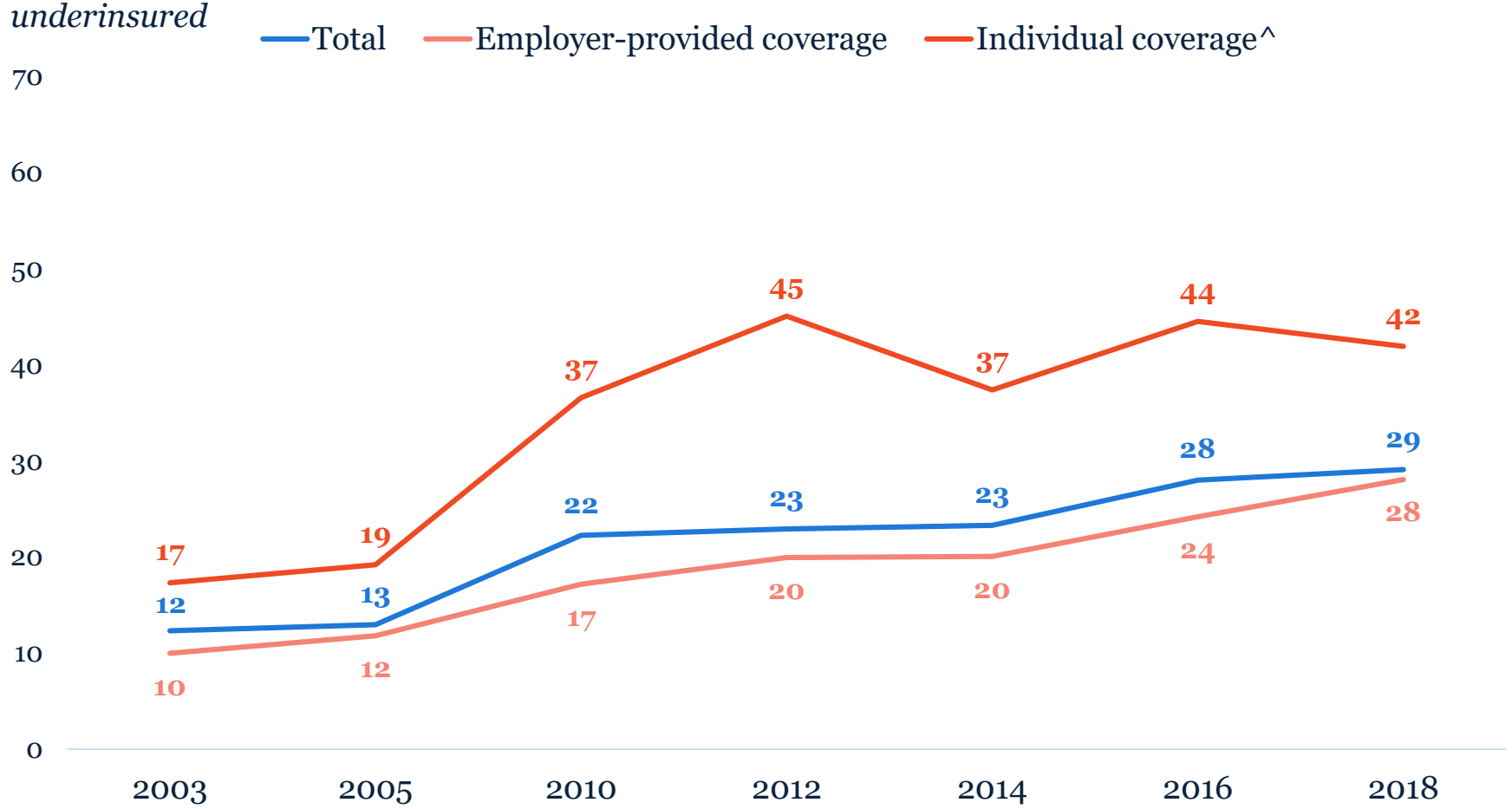
Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).

The Commonwealth Fund

Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

More Adults Are Underinsured, with the Greatest Growth Occurring Among Those with Employer Coverage

Percent of adults ages 19–64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

The Commonwealth Fund

Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

ATTACHMENT #2

IMPACT 2023

2020-2022 STRATEGIC PLAN

July 18, 2019

COOK COUNTY HEALTH

Focus Area 1

Deliver High Quality Care

COOK COUNTY HEALTH

Objective 1.1

Continuously improve clinical operations, practices and procedures across CCH to enhance quality, reliability, safety and efficiency.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.1 A Develop specific strategies and implementation plans related to the quality pillars (patient experience, readmissions, safe processes of care, clinical documentation, ambulatory pay for performance and mortality).	Achieve targets established by the High Reliability Organization (HRO) Committees. Exceed average/median external rating.
1.1 B Establish maternal/child health services at the community centers as key providers of maternal/child services. Assess and pilot additional strategies to support the continuum of maternal health services throughout the System.	Implement new maternal health navigator program at every health center that provides prenatal care. Increase 3% year-over-year prenatal visits; deliveries; newborn visits from a FY18 baseline of 6,205 prenatal visits; 987 deliveries; and 1,087 newborn visits.
1.1 C Enhance and reinforce organizational practices that improve a culture of safety and result in safe patient outcomes.	10% reduction in harm index over next three years.
1.1 D Improve the health status of patients by implementing the tenets of the medical home at CCH outpatient centers and practices that provide value.	Achieve benchmarks for HEDIS and Pay for Performance.
1.1 E Improve inpatient and ambulatory patient care by adopting strategies that move towards nursing Magnet® certification.	Achieve nursing-sensitive safety outcomes and process metrics (NDNQI Metrics) to allow consistent and meaningful progress towards Magnet®.
1.1 F Assure reliable supply chain to provide timely and safe clinical practice.	Streamline procurement process to reduce time to enter into contracts.
1.1 G Deploy appropriate emerging technology to improve portability and functionality.	Achieve HIMSS for Infrastructure certification; Implement Voice Over Internet Protocol (VOIP) system-wide.

Objective 1.1 Continued

Continuously improve clinical operations, practices and procedures across CCH to enhance quality, reliability, safety and efficiency.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.1 H Leverage IT in the clinical environment by using artificial intelligence and predictive analytics to improve patient care. Review the electronic medical record and determine if there are any untapped management tools to activate.	Finalize a plan on using artificial intelligence and predictive analytics by the 2nd quarter of 2020 that includes areas of focus and relevant metrics. Complete assessment of the Cerner Electronic Medical Record platform for additional management tools.
1.1 I Implement data governance model to improve data integrity and provide meaningful and timely reports to measure service performance against external benchmarks. Increase independent user access to data dashboards to improve knowledge, decision making and patient care.	Establish definitions and requirements for data input and provide routine reporting and real-time dashboards available for managers and for quality/performance oversight activities. Ability to produce ad hoc reports and generate data within established timelines. Increase number of dashboard users. Increase number of standard Cerner reports useful to local managers.
1.1 J Optimize health system integration and care transitions to benefit patients and the health system using an approach that is consistent with evidence-based practices.	Improved discharge planning that includes engaging the Patient Support Center. Reduce length of stay and improved utilization of appropriately reimbursable admission status.
1.1 K Modernize information technology infrastructure to improve the patient experience.	Implement free guest Wi-Fi across CCH where practical; strengthen cybersecurity; Refresh network infrastructure enabling faster network speeds, high availability, and next generation technologies; Fully optimize existing technology such as Tele-Tracking, TIGR to enhance patient care. Implement systems to ensure external providers can easily refer patients to CCH and receive results following new and follow up appointments.
1.1 L Assess contribution of Race, Ethnicity, and Language (REaL) factors to adverse events and develop mitigation strategies. Assess the contribution of disparities to health outcomes and adverse events. Determine if a patient's cultural or racial factors contribute to adverse outcomes and evaluate the causes of these outcomes. Focus quality efforts in areas that are directly impacted by disparities.	100% of intake staff are trained on how to accurately input race, ethnicity and language (REaL) data by 2022. Begin to validate and stratify outcomes data by REaL.
1.1 M Deploy applications that enhance services and facilitate exchange of clinical and public health data.	Analyses of clinical conditions informed by public health data sets to integrate into clinical practice strategies.
1.1 N Launch culturally-tailored health promotion programming and interventions. Shape our health centers to be culturally and linguistically sensitive.	Implement new health promotion program within community health centers by December 2020.

Objective 1.2

Develop systems that meet or exceed expectations and enhance the patient experience.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.2 A Implement best practices to enhance patient experience using data from patient satisfaction surveys. Use improvement strategies and support leadership strategies at the unit, department and site levels.	Continue to produce an annual patient experience plan informed by survey results. Improve patient ratings year-over-year.
1.2 B Develop comprehensive cultural competency strategy.	Train 100% of employees in cultural competency. Facilitate hiring of additional bi-lingual employees by increasing the number of bilingual job descriptions to 50, 75, 100 for 2020, 2021 and 2022 respectively, from a current baseline of 20.
1.2 C Launch initiatives focused on customer service, patient conveniences (e.g. Quiet Campaign).	Increase “willingness to recommend” to 60th percentile by 2022, up from the current 51st percentile.

Objective 1.3

Improve the availability of and access to health care, especially preventive care, for Cook County residents.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.3 A Enhance strategic partnerships with community providers.	CCH patient population meets HEDIS Medicaid target for an agreed upon set of metrics.
1.3 B Develop a roadmap of service needs by conducting a geographic analysis of providers, income, disease prevalence, etc., throughout the County to determine gaps in health services and recommend a service delivery plan.	Finalize comprehensive review of health care services (in 2020) in the County by provider type and population that can be updated, but would also include model/formula to explore and evaluate various expansion and/or partnership opportunities. Develop a multi-year strategy to grow CCH specialty services to meet community needs in a financially viable manner. Establish effective strategies that meet community needs and bring value to CCH.
1.3 C Complete a master facilities plan and make investments to make CCH more competitive.	Complete master facilities plan. Open new health facilities at Hanson Park, North Riverside, Blue Island, Harrison Square and the new Provident facility. Identify additional locations for health center expansions or replacements.
1.3 D Develop a comprehensive patient education strategy (e.g. diabetes prevention training, prenatal education, blood pressure self testing).	Establish inter-professional Patient Education committee for the System and establish metrics first quarter of 2020. 100% of diabetic patients are offered diabetic education, and 30% of diabetic patients receive diabetes management education by 2022. 100% of prenatal patients are offered prenatal education, and 30% complete entire prenatal education curriculum by 2022.
1.3 E Take advantage of state and federal initiatives to innovate care delivery services and programs, beneficial to patients and members.	Implement Integrated Health Homes if approved by the state.
1.3 F Mature behavioral health portfolio.	Full integration of behavioral health into primary care. Enhance Medication Assisted Treatment (MAT) infrastructure with workflow/pathway creation of level 1, 2, and 3 Behavioral Health services. Secure grant funding for opioid treatment and engage law enforcement partners in the development of deflection to treatment programs.
1.3 G Implement operational improvements to tap into unused capacity and create more access.	Set target of “third next available” appointments to less than 14 days for new specialty referrals. Target increase in eConsult use by 10%. Increase in-care list by 25% from FY2019 baseline. Pilot use of in-home monitoring for selected patient population (e.g. diabetes and hypertension).

Objective 1.4

Ensure a continuum of services to meet evolving needs to ensure continuity of care and meet patient needs at all stages of their lives.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.4 A Conduct analysis of services and identify gaps in the continuum of care to build valuable strategies for special populations (e.g. elderly, disabled, etc.).	Complete analysis and implementation plans on service gaps with recommendations on services to be provided by CCH or through partner organizations. Develop recommendations including on long-term care (including nursing home care), embedded care coordinators and senior care services in outpatient centers, home-based connections, telehealth, community-based care in lieu of institutionalization for elderly and special needs populations.

Objective 1.5

Integrate services with correctional health to improve health outcomes by ensuring continuation of care when individuals are released from correctional or detention facilities and reside in Cook County.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
1.5 A Improve transitions of care to the community through enhanced discharge planning.	Increase discharge planning such as the Naloxone Program and other warm hand-offs in the community by 20%. Expand transitions into community-based services through partnerships with CCH care management and PCMH providers, including linkages to housing, community based mental health providers. Establish community care coordination for justice-involved youth.

Focus Area 2

Grow to Serve and Compete

COOK COUNTY HEALTH

Objective 2.1

Establish CCH as a provider of choice.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
2.1 A Grow services lines that are needed by the community and deploy them geographically, in a patient-centered way to ensure CCH is providing the "right care at the right time and right place."	Primary Care: Volume of primary care patients increase by 3% year-over-year from a baseline of 92,143 primary care patients in FY2018. Specialty Care: Stroger Campus to provide for key specialties minimum 4 days/week, evening and Saturday hours. Provident Campus to provide full array of specialties minimum 3 days/week and evening hours. Provide selected specialties for new and expanded outpatient locations. Review all community locations to determine increased deployment of specialists for greater access to specialists.
2.1 B Maximize use of services and overall utilization.	Overall: Achieve 80% facility capacity utilization. Achieve 80% of primary care providers at productivity of 10 patients per session by 2022.; Provident: Reinstitute ambulance runs; Average Daily Census increase from 12 by 1.3% each year. ER Growth by 1.3% in FY 2020, 1% increase in FY 2021, 1% increase in FY 2022.
2.1 C Improve Stroger and Provident Hospital Emergency Department throughput.	Create an operational efficiency dashboard to include: Average time from ED arrival to ED departure for admitted ED patients; Average time from admit decision to ED departure time for admitted patients; Average arrival to ED departure for discharged ED patients; Physician discharge orders before 9:00 am; ED Left Without Being Seen (LWBS) to 2% by 2022.
2.1 D Market CCH services and strengthen the CCH brand.	Position CCH providers/leadership as thought leaders on quality and population health management. Complete rebranding process. Conduct market research. Develop consumer and non-consumer facing strategies to raise awareness of specialty care. Develop sponsorship strategy. Develop strategies to maintain CountyCare market share.
2.1 E Explore opportunities for CCH to be a provider for County employees as well as other employers.	Collaborate with Cook County Risk Management Department to explore feasibility, timing, and tactics to make CCH services a health service alternative.
2.1 F Minimize external referrals for care.	Internal referrals increase; eConsults increase (including by CCH providers); third next available is less than 14 days for new and follow up.
2.1 G Establish additional specific programs at Provident to maximize meeting the community needs.	Create Centers of Excellence for women's health (gynecology, cardiology, breast, endocrine), lifestyle center (dietary, fitness, chronic disease management), orthopedic center (podiatry, joints, hand), and men's health programs (urology, cardiology, endocrine).
2.1 H Maximize value of CCH resources (people, technology) to provide greater access to benefit patients.	Create an operating room dashboard to include: first case start times (target 80%), growth targets (10% per year), case cancellations rates (less than 5%), block utilization (95%) and operating room hours (80% utilization).Utilization of operating rooms at Provident and Stroger (80% of all operating room capacity). Implement telemedicine/tele psychiatry.

Objective 2.2

Retain and grow CountyCare market share.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
2.2 A Explore options in acquiring additional members through changes in the marketplace.	Gain auto-assignment for eligible justice-involved individuals in Cook County.
2.2 B Continue to implement a strong member retention and growth strategy to retain market share. Advocate for state policy changes that result in a simpler redetermination process.	Achieve plan redetermination at least 20% greater than the State.
2.2 C Enhance incentive programs and member benefits for improved health outcomes and member retention.	Offer a value-added benefit package that ties to quality outcomes, increases member engagement, and improves member retention.

Objective 2.3

Grow market share in nontraditional CCH populations.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
2.3 A Execute Medicare Advantage strategy that includes Chronic Conditions Special Needs Plan (C-SNP) persons with HIV; Institutional Special Needs Plan (I-SNP); Institutional Equivalent Special Needs Plan (IE-SNP); Medicare-Medicaid Alignment Initiative (MMAI).	Approval by CMS with Model of Care and Network for all three lines of business.
2.3 B Migrate to managed care capability including accepting risk.	Develop competencies in-house to evaluate and negotiate risk arrangements, and ensure CCH has the ability to accept managed care patients who are part of risk arrangements.

Focus Area 3

Foster Fiscal Stewardship

COOK COUNTY HEALTH

Objective 3.1

Optimize CCH revenue.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
3.1 A Maximize reimbursements from payors by continuing to improve operations, including revenue cycle improvements.	Increase MCO revenue by 10% each year from FY2019 baseline. Achieve 60% Pay for Performance (P4p) targets and benchmarks; Increase provider empanelment for MCOs to 80% of Medical Group Management Association (MGMA) or the FQHC benchmark. Reduce claims denials for managed care organizations by 80% from current levels and reduce accounts receivable. Improve authorization process for inpatient/observation care by Inpatient Care Coordination team for CountyCare members.
3.1 B Maximize extramural grant sources in alignment CCH initiatives, including primary care, maternal/child health, workforce development, behavioral health, HIV, social determinants of health and capital improvements; capture 10% indirect cost. Continue to build out the grants administrative infrastructure and increase the funds managed by CCH.	Increase extramural support by $5M annually, including capital. Increased alignment and coordination of extramural activities to improve impact.
3.1 C Continually improve documentation through ongoing provider feedback and provider education to support timely, complete and accurate billing.	Write and implement a three-year plan to improve documentation.
3.1 D Maximize auto-assignment for CountyCare.	Improve health plan quality and operational performance to assure maintaining and improving auto-assignments.
3.1 E Increase CountyCare membership in the Integrated Care Program (ICP) by assisting members with disabilities attain Social Security Income/Social Security Disability Income (SSI/SSDI).	Have RFP and procurement complete by 10/1/19 and vendor selection and engagement by FY2020. CountyCare will report on SSI/SSDI enrollment in Q2 2020.
3.1 F Identification of Skilled Nursing Facility and Home Health Partners for CountyCare members.	CountyCare SNF quality program requiring HFS approval has been submitted and is being reviewed by the State.
3.1 G Advocate for local government financial support of unfunded mandates such as correctional health and public health services.	Public and Correctional Health expenses continue to be covered by local taxpayer support.
3.1 H Optimize information technology infrastructure to improve revenue capture and financial reporting.	Successful implementation of patient accounting system, online bill payment, online financial counseling and routine financial reporting.

Objective 3.2

Control costs and maximize efficiencies.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
3.2 A CountyCare to continue implementation of Medical Cost Action Plan that all CountyCare departments participate in to reduce costs through a combination of operational efficiencies and recontracting.	Achieve $30 million in savings to CountyCare plan, while preserving excellence in clinical services and plan operations.
3.2 B Increasing full-time employees, reducing agency and overtime costs.	Streamline and automate processes that reduce time to hire and expedite other human resource processes. Reduction in vacancies to 10% of workforce.
3.2 C Maximize lab automation through cross-training and filling vacant positions.	Achieve 98% error free rate.
3.2 D Utilize data (volume, unit costs) to ensure staffing is in-line with appropriate best practices.	Establish annual targets based on industry benchmarks for overall staffing, including overtime and agency staffing that align with volumes and clinical complexity.
3.2 E Evaluate training programs to determine optimal size and CCH strategic and fiscal value.	Assessment of 2 physician training programs with recommendations to leadership about strategic and financial attributes to inform organizational planning.
3.2 F Conduct event review and overall analysis for all litigation and implement and communicate lessons learned to mitigate financial risks through employee training.	With Risk Management, identify litigation trends and implement strategic interventions where appropriate to minimize risk. Continue trainings for staff across the organization on topics like litigation, informed consent, following event reporting and evaluation protocols in order to preserve privileges in litigation matters.
3.2 G Reduce facility expenses.	Complete close out of health system operations at the Oak Forest property and fully transferred Oak Forest maintenance to the County. Establish internal construction team to reduce facility rehab costs. Move all remaining employees out of the Polk Administration building to allow the County to proceed with building decommissioning. Integrate CORE facility maintenance into CCH portfolio. Review the structure of the building and maintenance division and leverage these resources across all of CCH locations.
3.2 H Transition high volume network providers to value-based contracts for CountyCare.	Execute at least one significant contract with a network provider that transfers risk while preserving excellence in member services in 2020.
3.2 I Improve competition for CCH contracted work by increasing transparency of what we plan to procure each year.	Establish Annual Buying Plan and increase MBE/WBE contract participation.

Objective 3.3

Pharmaceutical Management.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
3.3 A Optimize pharmacy economics.	Optimize Revenue: Identify contractual opportunities to increase pharmacy reimbursement for current formulary products. Insource specialty pharmaceuticals creating opportunity to generate revenue. Minimize Expenses: Maximize use of programs available that will reduce medication expense (such as 340B program) or that will allow eligible patients to obtain required medications through external programs (such as insurance Medication Assistance Programs). Reduce practice variation, especially around chronic disease management, to ensure prescriptions are evidence-based, decreasing variation of drug uses among expense classes.

Focus Area 4

Leverage and Invest in Assets

COOK COUNTY HEALTH

Objective 4.1

Recruit, hire and retain the best employees, who are committed to CCH's mission.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.1 A Finalize implementation of online performance evaluations.	Performance evaluations done online for all personnel.
4.1 B Develop an industry-based class and compensation strategy to recruit, hire and retain the best employees to support the continued transformation of the organization.	Create performance-based pay plan for non-union employees.
4.1 C Analyze and develop solutions for employee transportation needs.	Complete analysis of actionable recommendations, considerate of other local employers.

Objective 4.2

Strengthen the CCH Workforce.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.2 A Enhance workforce training opportunities.	Develop curriculum for CCH employee to develop/enhance skill sets. Training catalogue created detailing all training available across CCH.
4.2 B Conduct an analysis of organizational leadership by span of control, bench strength and develop an approach to succession planning.	Complete analysis of actionable recommendations, considerate of other local employers.
4.2 C Review of competency-based, "top of license" model of care across the System.	Update Advanced Practice Provider job descriptions to have more defined requirements and clinical activity expectations. Implement plan to optimize roles of Community Health Workers and Psychologists.
4.2 D Develop strategies that foster flexibility and career development for unionized employees.	Establish career ladders within specialized technical positions. Increase online and interactive training courses to enhance supervisory skills. Develop opportunities for entry level positions to train for more technical positions (e.g. Building Service Worker to Medical Assistant).
4.2 E Pursue partnerships with nursing schools to foster and grow recruitment of excellent and culturally-competent nurses to CCH.	Establish one partnership and complete a cost/benefit analysis of a nursing residency program. Relevant metrics to gauge success are: nursing turnover rate by tenure, number of new hires by colleges and number of schools of nursing partnerships.
4.2 F Improve the continuous learning environment of CCH and conduct an ongoing review of the effectiveness of academic affiliations.	Identify benefits resulting to both CCH and University of Illinois with a finalized agreement with University of Illinois School of Public Health. Assess master affiliation agreements in alignment with clinical priorities.

Objective 4.3

Leverage CCH workforce.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.3 A Develop and execute employee engagement action plans based on learnings from the employee engagement survey. Enhance collaboration with labor to further employee engagement.	Establish employee recognition/awards program.
4.3 B Strengthen inter-departmental communications and collaboration better-coordinated services and improved patient outcomes.	Improve patient outcomes and Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) scores related to teamwork. Decrease in number of patient grievances and increase in employee satisfaction.
4.3 C Support an environment of continuous process improvement by increasing managers' competencies using process improvement and project management tools.	Standardize process improvement approach to projects. Identify professional membership(s) to support ongoing process improvement. Train all managers on process improvement.
4.3 D Support board development and leverage CCH Board of Directors as resources.	Create an annual calendar that anticipates strategic presentations to the Board. Board to complete an annual self-assessment process regarding best governance practices and incorporates opportunities identified into changes in board practices.

Objective 4.4

Utilize industry benchmarking and tools to improve quality, cost, utilization and patient outcomes.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.4 A Establish staffing productivity model to optimize efficiency and effectiveness for key areas (e.g. nursing, environmental services). Develop a predictive staffing model/variable workload staffing model.	Reduce nursing overtime by 25%, decrease agency usage by 50% by 2021.
4.4 B Develop the ability to analyze specific initiatives to determine mission alignment and attainment of outcomes.	Establish defined process for approval of new programs and initiatives.
4.4 C Evaluate outcome data and utilization patterns to determine the efficacy of various system strategies (e.g. care coordination).	Provided actionable analysis of the efficacy of care coordination strategies.
4.4 D Update Clinical, Administrative, Research and Teaching (CART) process to review and standardize expectations and that actuals are aligned with these expectations. Distribute dashboards to benchmark performance on CART and Relative Value Units (RVU) at the physician and department level.	Annual review of CART expectations to be part of the annual performance appraisal of clinical chairs as a routine review of results against expectations. Provide and mature Relative Value Units (RVUs) reports for providers and managers. Establish RVU reporting with accurate information routinely reported using data in Cerner system.
4.4 E Mature health plan network strategy to assure access, quality, and value.	Develop and implement a managed care strategic roadmap to address payor prioritization/portfolio, matching the delivery system to managed care opportunities to increase year-over-year increase in utilization of CCH as a provider.

Objective 4.5

Utilize CCDPH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.5 A Develop system-wide strategies to reduce transmissible infections.	Pilot two mass screenings events in high-risk communities by 2021. Institute expedited partner therapy in 100% of CCH community health centers by 2020. Establish media/social media campaign to raise awareness and promote testing of sexually active adolescents and adults. Establish walk-in diagnostic and treatment capacity at all CCH primary care sites with expedited results.
4.5 B Maximize local health collaboration, partnership and alignment in Cook County to inform services, with local health departments such as City of Chicago Department of Public Health and local resources such as the University of Illinois School of Public Health.	Continue collaborative work on public health initiatives and identify additional areas for collaboration and/or synergy of efforts at shared objectives.
4.5 C Explore establishing additional injury-prevention partnerships and programs.	Develop program to reduce injuries, improve population health and identify external funds.

Objective 4.6

Increase community engagement.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.6 A Leverage outpatient health centers as community anchors by partnering with community organizations. Continue rolling out community advisory boards for all outpatient health centers. Develop a strategy to ensure community engagement across the county.	Establish community advisory boards at all outpatient health centers.

Objective 4.7

Align extramural funding efforts with core competencies and strategies.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
4.7 A Mature grant opportunity review process to include an evaluation of potential grants based on CCH strategy, expected cost/benefit and clinical or research alignment.	Establish process to evaluate grant opportunities to ensure alignment with strategic priorities, organizational leadership and cost/benefit. Establish a minimum grant value.

Focus Area 5

Impact Social Determinants and Advocate for Patients

COOK COUNTY HEALTH

Objective 5.1

Tailor Social Determinant of Health strategies to achieve the most impact on CCH patients and Health Plan members.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
5.1 A Establish cross-departmental stakeholder group to create a plan to address social determinants of health for CCH populations.	Create work group. Understand the needs of specific populations and develop tailored service plans.
5.1 B Leverage CountyCare data, including Health Risk Assessments (HRAs) to identify needed value-added benefits to membership related to social determinants of health and serve that improve health status.	Routine review of CountyCare data to make recommendations on additional value-added benefits that may be needed.
5.1 C Partner with other organizations to address population health care needs outside of the health care system, including those related to food insecurity.	Continue "Food as Medicine" program to all outpatient sites. Evaluation complete related to onsite food pantries. Increase clients receiving Women, Infants and Children (WIC) services by 3% year over year. Convene CCDPH Food Summit and develop and distribute CCDPH Food Summit report. Organize and facilitate quarterly Cook County Good Food Task Force meetings and implement recommendations.
5.1 D Grow and mature the housing strategy to improve patient outcomes.	Create criteria for long-term care (custodial) admissions to divert to housing with support services. Facilitate housing for CCH patients in CCH permanent supportive-housing models. Reduce unnecessary visits to the Emergency Department by homeless individuals by partnering with community-based organizations on innovative care solutions.
5.1 E Educate local, state and federal officials on policies and practices that affect CCH populations.	Gain auto-assignment for eligible justice-involved in Cook County.
5.1 F Collaborate nationally with county government stakeholders and large urban health care systems to garner congressional support to garner support for legislation that furthers the mission of CCH on shared policy priorities and targeted advocacy efforts.	Advocate for reinstating county eligibility in the National Health Services Corps (NHSC) loan forgiveness program.
5.1 G Utilize CCH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health and trauma-informed approaches.	Successfully implement strategies identified in the CCH Trauma-Informed Approaches Taskforce report. Track the number of staff trained in trauma-informed approaches and the number of designated trauma champions in each department.
5.1 H Develop focused program on populations that would benefit from better engagement in health care who are less likely to engage in appropriate preventive care.	Expand pilot program to provide outreach and engagement of 100 African American men by 2023 on hypertension and apply lessons learned across all outpatient sites.

Objective 5.2

Elevate organizational contributions to mitigate disparities.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
5.2 A Maximize external recognition of CCH best practices.	Establish center for Health Equity and Innovation. Convene quarterly research and innovation summits. Present CCH correctional best practices to other correctional health departments (e.g. Naloxone distribution, dental health, women's health).
5.2 B Work with Cook County government to advance a Health in All Policies (HiAP) approach that incorporates health, equity and sustainability considerations into decision-making across sectors and policy areas to improve the quality of life of its residents.	Convene internal CCDPH team to lead research and process development and implementation. Outreach to other local governments implementing HiAP to obtain lessons learned. Propose process to Cook County government to explore advancement of HiAP. Implement process with Cook County government to identify best mechanism to advance HiAP.
5.2 C Support the Cook County Complete Count Census Commission in their efforts to ensure that all Cook County residents are counted in the 2020 Census.	Share CCH and CCDPH information with patients, providers, and community stakeholders on the importance of Census participation.
5.2 D Increase MBE/WBE participation on contracts.	Steadily increase MBE/WBE participation annually through an enhanced CCH outreach efforts and targeted programs with Group Purchasing Organizations (GPOs).

Objective 5.3

Utilize CCH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health.

HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
5.3 A Advocate for the adoption of a Cook County Lead Poisoning Prevention Ordinance.	Complete steps necessary for adoption, approval and implementation.
5.3 B Expand the use of population and epidemiologic data to identify upstream drivers of chronic diseases and conditions, improve birth outcomes and enhance childhood development.	Increase resources for patients and the community. Develop new partnerships to address key drivers of health inequity.
5.3 C Identify opportunities to partner with other governments and organizations to address gun violence, opioid abuse, and sexually transmitted infections.	Develop two initiatives that promote partnership with shared objectives.

Strategic Planning Timeline

COMPLETED

Nov

- Population Overview and Projections

Dec

- Environmental Assessment: Epidemiology, Health status and disparities in Cook County
- Information Technology

Jan

- Financial Status and Pressures
- State and Federal Issues

Feb

- Human Resources
- Pension Overview
- Quality
- Extramural Funding
- Health Equity and Social Determinants
- Correctional Health
- Behavioral Health
- Safety net strategies/ vulnerabilities, local market realities, partnerships

March

- Integrated Care
- Medicaid Managed Care/Managed Populations
- Research
- Clinical Activity, Utilization & Operational Efficiency
- Medical Practice/ Medical Group

April

- Nursing
- Graduate Education
- Capital Investment
- Primary Care/ Maternal Child Care
- Diagnostic/ Specialty Services
- Marketing, Communications & Branding
- Community Health Improvement Plans/CCDPH
- Community/ Employee Meetings

May

- Community/ Employee Meetings
- Financial Forecasting Scenarios

June 28

- Discussion of preliminary draft at full board meeting

July 15

- Draft plan issued for employee and public review and comment

UPCOMING

July 18

- Special board meeting to present analysis of the uninsured and discuss the draft plan

July 26

- Anticipated approval of 2020-2023 Strategic Plan

August/September

- Inclusion of financial forecast and submission of plan to Cook County Board of Commissioners.

Thank you.

COOK COUNTY HEALTH